

LIFE, ACCIDENT AND HEALTH INSURERS

COMPANY NAME: _____ NAIC Company Code: _____
 Contact: _____ Telephone: _____
 REQUIRED FILINGS IN THE STATE OF: MONTANA Filings Made During the Year 2009

(1) Check- list	(2) Line #	(3) REQUIRED FILINGS FOR THE ABOVE STATE	(4) NUMBER OF COPIES*			(5) DUE DATE	(6) FORM SOURCE**	(7) APPLICABLE NOTES
			Domestic		Foreign			
			State	NAIC	State			
		I. NAIC FINANCIAL STATEMENTS						
	1	Annual Statement (8 1/2"x14")	1	EO	xxx	3/1	NAIC	A thru N
	1.1	Printed Investment Schedule detail (Pages E01-E27)	1	EO	xxx	3/1	NAIC	A thru N
	2	Quarterly Financial Statement (8 1/2" x 14")	1	EO	xxx	5/15, 8/15, 11/15	NAIC	A thru N
	3	Separate Accounts Annual Statement (8 1/2"x14")	1	EO	xxx	3/1	NAIC	A thru N
		II. NAIC SUPPLEMENTS						
	10	Accident & Health Policy Experience Exhibit	1	EO	xxx	4/1	NAIC	A thru N
	11	Actuarial Certification Related Annuity Nonforfeiture Compliance	1	EO	xxx	3/1	Company	A thru N
	12	Actuarial Opinion on X-Factors	1	EO	xxx	3/1	Company	A thru N
	13	Actuarial Opinion on Separate Accounts Funding	1	EO	xxx	3/1	Company	A thru N
	14	Actuarial Opinion on Synthetic Guaranteed Investment Contracts	1	EO	xxx	3/1	Company	A thru N
	15	Credit Insurance Experience Exhibit	1	EO	xxx	4/1	NAIC	A thru N
	16	Interest Sensitive Life Insurance Products Report	1	EO	xxx	4/1	NAIC	A thru N
	17	Investment Risk Interrogatories	1	EO	xxx	4/1	NAIC	A thru N
	18	Life, Health & Annuity Guaranty Assessment Base Reconciliation Exhibit	1	EO	xxx	4/1	NAIC	A thru N
	19	Life, Health & Annuity Guaranty Assessment Base Reconciliation Exhibit Adjustment Form	1	EO	xxx	4/1	NAIC	A thru N
	20	Long Term Care Experience Reporting Forms	1	EO	xxx	4/1	NAIC	A thru N
	21	Management Discussion & Analysis	1	EO	xxx	4/1	Company	A thru N
	22	Medicare Supplement Insurance Experience Exhibit	1	EO	xxx	3/1	NAIC	A thru N
	23	Medicare Part D Coverage Supplement	1	EO	xxx	3/1, 5/15, 8/15, 11/15	NAIC	A thru N
	24	Reasonableness of Assumptions Certification	1	EO	xxx	3/1, 5/15, 8/15, 11/15	Company	A thru N
	25	Reasonableness & Consistency of Assumptions Cert.	1	EO	xxx	3/1, 5/15, 8/15, 11/15	Company	A thru N
	26	Reasonableness of Assumptions Cert. for Implied Guaranteed Rate Method	1	EO	xxx	3/1, 5/15, 8/15, 11/15	Company	A thru N
	27	Reasonableness & Consistency of Assumptions Cert. (Updated Average Market Value)	1	EO	xxx	3/1, 5/15, 8/15, 11/15	Company	A thru N
	28	Reasonableness & Consistency of Assumptions Cert. (Updated Market Value)	1	EO	xxx	3/1, 5/15, 8/15, 11/15	Company	A thru N
	29	Risk-Based Capital Report	1	EO	xxx	3/1	NAIC	A thru N
	30	RBC Certification required under C-3 Phase I	1	EO	xxx	3/1	Company	A thru N
	31	RBC Certification required under C-3 Phase II	1	EO	xxx	3/1	Company	A thru N
	32	Schedule SIS	1	N/A	N/A	3/1	NAIC	A thru N
	33	Statement of Actuarial Opinion	1	EO	xxx	3/1	Company	A thru N, Y
	34	Statement on non-guaranteed elements - Exhibit 5 Int. #3	1	EO	xxx	3/1	Company	A thru N
	35	Statement on par/non-par policies - Exhibit 5 Int. 1.1	1	EO	xxx	3/1	Company	A thru N
	36	Supplemental Compensation Exhibit	1	N/A	N/A	3/1	NAIC	A thru N
	37	Supplemental Schedule O	1	EO	xxx	3/1	NAIC	A thru N
	38	Trusteed Surplus Statement	1	EO	xxx	3/1, 5/15, 8/15, 11/15	NAIC	A thru N
	39	Workers' Compensation Carve Out Supplement	1	EO	xxx	3/1	NAIC	A thru N
		III. ELECTRONIC FILING REQUIREMENTS						
	40	Annual Statement Electronic Filing	xxx	1	xxx	3/1	NAIC	
	41	March .PDF Filing	xxx	1	xxx	3/1	NAIC	
	42	Risk-Based Capital Electronic Filing	xxx	1	N/A	3/1	NAIC	
	43	Risk-Based Capital .PDF Filing	xxx	1	N/A	3/1	NAIC	
	44	Separate Accounts Electronic Filing	xxx	1	xxx	3/1	NAIC	
	45	Separate Accounts .PDF Filing	xxx	1	xxx	3/1	NAIC	
	46	Supplemental Electronic Filing	xxx	1	xxx	4/1	NAIC	
	47	Supplemental .PDF Filing	xxx	1	xxx	4/1	NAIC	
	48	Quarterly Statement Electronic Filing	xxx	1	xxx	5/15, 8/15, 11/15	NAIC	
	49	Quarterly .PDF Filing	xxx	1	xxx	5/15, 8/15, 11/15	NAIC	
	50	June .PDF Filing	xxx	1	xxx	6/1	NAIC	
		IV. AUDITED FINANCIAL STATEMENTS						
	61	Accountants Letter of Qualifications	1	N/A	N/A		Company	A, B, E, I, J, K, X
	62	Audited Financial Statements	1	EO	xxx	6/1	Company	A, B, E, I, J, K, X
	63	Audited Financial Statements Exemption Affidavit	1	N/A	N/A		Company	A, B, E, I, J, K, X
	64	Independent CPA	1	N/A	N/A		Company	A, B, E, I, J, K, X
	65	Notification of Adverse Financial Condition	1	N/A	N/A		Company	A, B, E, I, J, K, X
	66	Report of Significant Deficiencies in Internal Controls	1	N/A	N/A		Company	A, B, E, I, J, K, X
	67	Request for Exemption to File	1	N/A	N/A		Company	A, B, E, I, J, K, X
		V. STATE REQUIRED FILINGS						
	101	Certificate of Compliance	0	0	1	3/1	Domicile	A, B, E, O
	102	Certificate of Deposit	0	0	1	3/1	Domicile	A, B, E, P
	103	Certificate of Valuation	0	0	1	3/1	Company	A, B, E, Q
	104	Copy of Annual Statement Montana State Page w/Tax Report	1	0	1	3/1	Company	A, B, E
	105	Filings Checklist Page 1 (with Column 1 completed)	1	0	1	3/1	State	A, B, E
	106	Genetics Program Charge (SAI 26)	1	0	1	3/1	State	A, B, E, R
	107	Holding Company Statement	1	0	0	4/30	State	A, B, E
	108	Insurance Department Financial Examination Report	0	0	1	When available	Domicile	A, B, E, S
	109	Montana Comprehensive Health Association (MCHA) Survey	1	0	1	3/1	State	A, B, E, T
	110	Montana Premium Tax Report & Remittance (SAI 27)	1	0	1	3/1	State	A thru F
	111	Quarterly Premium Tax Prepayment Forms (SAI 22)	1	0	1	4/15, 6/15, 9/15, 12/15	State	A, B, D, E, F, U
	112	Report of Insured Montana Residents	1	0	1	3/1	State	A, B, E, V
	113	Small Employer Group Activity Report (SEHRP-08)	1	0	1	3/1	State	A, B, E, W
	114	Funeral Insurance Activity Report (FIAR-08)	1	0	1	3/1	State	A, B, E, AA
	115	State Filing Fees	1	0	1	3/1	State	A, B, C, E, F
	116	Signed Jurat	0	xxx	1	3/1	NAIC	A, B, E, L

*If XXX appears in this column, this state does not require this filing, if hard copy is filed with the state of domicile and if the data is filed electronically with the NAIC. If N/A appears in this column, the filing is required with the domiciliary state. EO (electronic filing only). **If Form Source is NAIC, the form should be obtained from the appropriate vendor.

	NOTES AND INSTRUCTIONS (A-K APPLY TO ALL FILINGS)
A	<p>Required Filings Contact Person:</p> <p>Montana Insurance Department, Examinations Bureau: 406-444-2040 or Fax 406-444-3497 E-mail Addresses: Cheryl Donovan at cdonovan@mt.gov; Michelle Scaccia at mscaccia@mt.gov; Tim Morris at tmorris@mt.gov; Wayne Barker at wbarker@mt.gov</p>
B	<p>Mailing Address:</p> <p>Montana Insurance Department Examinations Bureau 840 Helena Avenue Helena, MT 59601</p>
C	<p>Mailing Address for Filing Fees:</p> <p>Mailing address is same as above. The fee of \$1,900 should be included with the premium tax form and payment due March 1. If due date falls on weekend or holiday, deadline is extended to next business day.</p>
D	<p>Mailing Address for Premium Tax Payments:</p> <p>Same as B.</p>
E	<p>Delivery Instructions: Make checks payable to "Commissioner of Insurance, State of Montana." All filings must be postmarked no later than the indicated due date. If due date falls on weekend or holiday, deadline is extended to next business day.</p> <p>The premium tax return (Form SAI 27) with attachments and any payment is due March 1. A copy of the annual statement Montana State Page should be attached to the tax return. If possible, the tax return should be printed on blue paper.</p> <p>If you are completing tax returns for several affiliated companies within a group, and some or all of the companies have a net amount due, please attach a separate check for each company. DO NOT combine amounts for groups of companies.</p> <p>Note that the tax return requires all companies remit a check for \$1,900 in payment of all Montana filing and renewal fees, plus additional premium taxes due. In the event your company has overpaid premium taxes in 2008, and the overpayment credit is subsequently confirmed by this Department, the credit must be applied toward 2009 quarterly premium tax prepayments.</p> <p>Montana Administrative Rules pertaining to tax payments: <u>6.6.2706 Adjustments</u> (1) Over the course of the calendar year, the insurer shall make the periodic payment in the amounts specified by ARM 6.6.2704. Any adjustments in the amounts paid must be made in conjunction with the filing of the report and payment of tax on March 1 of each year. Any credit must be carried forward and used to offset future periodic payments. <u>6.6.2704 Methods of Calculation</u> (1) Every insurer shall pay its quarterly premium tax obligation as follows: (a) pay an amount equal to 100% of its prior calendar year premium tax in four equal payments, or (b) pay an amount equal to 90% of current year premium tax obligation, as calculated pursuant to 33-2-705(2), MCA, in four equal payments. <u>6.6.2707 Cessation of Business</u> (1) If an insurer, on a form approved by the commissioner and under oath, notifies the commissioner that it is no longer writing new or renewing existing insurance policies of any type in the state, the commissioner may waive the periodic payment requirements established in these rules. <u>6.6.2708 Application of Refund</u> (1) If an insurer, on a form approved by the commissioner and under oath, notifies the commissioner that it is entitled to a refund, the commissioner may authorize a refund. An insurer is not entitled to receive interest on the refund.</p>
F	<p>Late Filings:</p> <p>The commissioner may impose a fine [Sections 33-2-701(7) and 33-2-705(6), MCA] if filings are not made in time provided, or suspend or revoke the certificate of authority of any insurer that fails to pay taxes as required. [Section 33-2-705(5), MCA]</p>

G	<p>Original Signatures:</p> <p>Domestic insurers must submit an annual statement with original signatures on the Jurat page. Foreign insurers may use facsimile signatures or reproductions of original signatures on Signed Jurat page.</p>
H	<p>Signature/Notarization/Certification:</p> <p>Domestic insurers' annual statement must be verified by the oath of the insurer's president or vice-president and secretary or, if a reciprocal insurer, by the oath of the attorney-in-fact or its like officers if a corporation.</p>
I	<p>Amended Filings:</p> <p>See NAIC Annual Statement Instructions for guidance on amended filings.</p>
J	<p>Exceptions from normal filings:</p> <p>Companies must submit a written request for an exemption or extension to the Department of Insurance. Foreign companies must include a copy of any exemption or extension received by its state of domicile to receive such from Montana.</p>
K	<p>Bar Codes (State or NAIC):</p> <p>Montana is not currently using Bar Codes.</p>
L	<p>Signed Jurat:</p> <p>Montana waives foreign insurers from filing printed annual statements and NAIC supplements if filed with the state of domicile and the NAIC, and if filed electronically with the NAIC. The Signed Jurat page is due March 1. Facsimile signatures or reproductions of original signatures may be used. In the event that any financial data is refiled or amended, a newly completed Jurat page is required.</p>
M	<p>NONE Filings:</p> <p>See NAIC Annual Statement Instructions. Exceptions are noted in the instructions.</p>
N	<p>Filings new, discontinued or modified materially since last year:</p> <p>None of the filings have been discontinued since last year.</p> <p>New NAIC Supplement Filings: Actuarial Certification Related Annuity Nonforfeiture Compliance; Actuarial Opinion on X-Factors; Actuarial Opinion on Separate Accounts Funding; Actuarial Opinion on Synthetic Guaranteed Investment Contracts; RBC Certification required under C-3 Phase I; RBC Certification required under C-3 Phase II.</p> <p>Electronic Filings: Risk-Based Capital. PDF Filing.</p> <p>Modified: Genetics Program Charge is now \$1.00 See Note R.</p>
O	<p>Certificate of Compliance:</p> <p>Each foreign insurer shall file a Certificate of Compliance issued by the public official having supervision of insurance in the insurer's state of domicile. It shall certify that the company is duly organized and authorized to transact insurance therein and the kinds of insurance it is authorized to transact. Due March 1.</p>
P	<p>Certificate of Deposit:</p> <p>Each foreign insurer shall file a Certificate of Deposit issued by the official having supervision of insurance in the insurer's state of domicile. It shall certify the amount and the composition of the deposit maintained by the insurer in another state for the protection of all policyholders. Due March 1.</p>
Q	<p>Certificate of Valuation:</p> <p>Each foreign insurer shall file a Certificate of Valuation issued by the official having supervision of insurance in the insurer's state of domicile. Due as soon as available.</p>
R	<p>Genetics Program Charge Form (SAI 26):</p> <p>Pursuant to Section 33-2-712 MCA, an insurer is required to pay a fee of \$1.00 to the Commissioner of Insurance per Montana resident insured under any individual or group disability or health insurance policy on February 1 of each year. Any payment due for Genetics Program Charges should be made by attaching a SEPARATE CHECK FOR THE AMOUNT DUE. A Genetics Program Charge Form is enclosed in your packet if your company is licensed to transact Disability (Health) insurance in Montana. Due March 1. REPORT IS DUE EVEN IF REPORTING ZERO.</p>
S	<p>Insurance Department Financial Examination Report:</p> <p>A copy of the domicile state examination report of foreign insurers is required to be filed with this Department as soon as the report is filed by the domicile state as a public document. An electronic filing is accepted in lieu of hard copy filing if filed electronically with the NAIC.</p>

T	<p>Montana Comprehensive Health Association (MCHA) Survey:</p> <p>This report is enclosed if your company is licensed to transact Disability (Health) insurance in Montana. Due March 1.</p> <p>REPORT IS DUE EVEN IF REPORTING ZERO.</p>
U	<p>Quarterly Premium Tax Forms and Instructions (SAI 22):</p> <p>Pursuant to Section 33-2-705(7) MCA, and Montana Administrative Rules 6.6.2701 – 6.6.2709, an insurer operating in Montana is required to remit its 2009 premium taxes on a quarterly basis on or before the 15th day of the following months: April, June, September, and December.</p> <p><u>6.6.2704 Methods of Calculation</u> (1) Every insurer shall pay its quarterly premium tax obligation as follows: (a) pay an amount equal to 100% of its prior calendar year premium tax in four equal payments, or (b) pay an amount equal to 90% of current year premium tax obligation, as calculated pursuant to 33-2-705(2), MCA, in four equal payments.</p> <p><u>6.6.2707 Cessation of Business</u> (1) If an insurer, on a form approved by the commissioner and under oath, notifies the commissioner that it is no longer writing new or renewing existing insurance policies of any type in the state, the commissioner may waive the periodic payment requirements established in these rules.</p> <p>Include with the 2009 quarterly premium tax remittances a completed voucher form SAI 22. Each insurer is required to file the quarterly prepayment forms with the Department even if no payment is due. If no direct business will be written in Montana during 2009, <u>return all four voucher forms marked “zero” with the April 15 filing.</u></p> <p>The quarterly premium tax prepayment forms contain line-by-line calculation information, along with additional instructions on the reverse of the quarterly forms.</p>
V	<p>Report of Insured Montana Residents:</p> <p>This report is enclosed if your company is licensed to transact Disability (Health) insurance in Montana. Due March 1.</p> <p>REPORT IS DUE EVEN IF REPORTING ZERO.</p>
W	<p>Small Employer Group Activity Report (SEHRP-08):</p> <p>This report is enclosed if your company is licensed to transact Disability (Health) insurance in Montana. Due March 1.</p> <p>REPORT IS DUE EVEN IF REPORTING ZERO.</p>
X	<p>Audited Financial Statements:</p> <p>FOREIGN INSURERS ONLY – Please refrain from submitting the Audited Financial Statements to this office until further notice.</p>
Y	<p>Statement of Actuarial Opinion:</p> <p>Domestic insurers are required to submit the actuarial opinion, including a copy of the actuarial report supporting the actuarial opinion together with related actuarial work papers. Due March 1.</p>
AA	<p>Funeral Insurance Activity Report (FIAR-08) NEW as of 1/1/2008. ARM 6.6.1008 provides that the Commissioner may require issuers of funeral insurance to file a supplement to the annual statement. Funeral insurance is a type of life insurance as defined in MCA 33-20-1501 and may be included in a life insurance policy or a limited policy or certificate with a guaranteed death benefit</p> <p>This report is enclosed if your company is licensed to transact Life insurance in Montana. Due March 1. REPORT IS DUE EVEN IF REPORTING ZERO.</p>

**General Instructions
For Companies to Use Checklist**

Please Note: This state's instructions for companies to file with the NAIC are included in this Checklist. The NAIC will not be sending their own checklist this year.

Electronic filing is intended to include filing via the Internet or via diskette with the NAIC. Companies that file with the NAIC via the Internet are not required to submit diskettes to the NAIC. Companies are not required to file hard copy filings with the NAIC.

Column (1) (Checklist) Companies may use the checklist to submit to a state, if the state requests it. Companies should copy the checklist and place an "x" in this column when mailing information to the state.

Column (2) (Line #) Line # refers to a standard filing number used for easy reference. This line number may change from year to year.

Column (3) (Required Filings) Name of item or form to be filed.

The **Annual Statement Electronic Filing** includes the annual statement data and all supplements due March 1, per the *Annual Statement Instructions*. This includes all detail investment schedules and other supplements for which the *Annual Statement Instructions* exempt printed detail.

The **March .PDF Filing** is the .pdf file for annual statement data, detail for investment schedules and supplements due March 1.

The **Risk-Based Capital Electronic Filing** includes all risk-based capital data.

The **Risk-Based Capital .PDF Filing** is the .pdf file for risk-based capital data.

The **Separate Accounts Electronic Filing** includes the separate accounts annual statement and investment schedule detail.

The **Separate Accounts .PDF Filing** is the .pdf file for the separate accounts annual statement and all investment schedule detail.

The **Supplemental Electronic Filing** includes all supplements due April 1, per the *Annual Statement Instructions*.

The **Supplement .PDF Filing** is the .pdf file for all supplemental schedules and exhibits due April 1.

The **Quarterly Electronic Filing** includes the quarterly statement data.

The **Quarterly .PDF Filing** is the .pdf for quarterly statement data.

The **June .PDF Filing** is the .pdf file for the Audited Financial Statements.

Column (4) (Number of Copies) Indicates the number of copies that each foreign or domestic company is required to file for each type of form. The Blanks (E) Task Force modified the 1999 *Annual Statement Instructions* to waive paper filings of certain NAIC supplements and certain investment schedule detail, if such investment schedule data is available to the states via the NAIC database. The checklists reflect this action taken by the Blanks (EX4) Task Force. XXX appears in the "Number of Copies" "Foreign" column for the appropriate schedules and exhibits. . **Some states have chosen to waive printed quarterly and annual statements from their foreign insurers and to rely upon the NAIC database for these filings. This waiver could include supplemental annual statement filings. The XXX in this column might signify that the state has waived the paper filing of the annual statement and all supplements.**

Column (5) (Due Date) Indicates the date on which the company must file the form.

Column (6) (Form Source) This column contains one of three words: "NAIC," "State," or "Company," If this column contains "NAIC," the company must obtain the forms from the appropriate vendor. If this column contains "State," the state will provide the forms with the filing instructions. If this column contains "Company," the company, or its representative (e.g., its CPA firm), is expected to provide the form based upon the appropriate state instructions or the NAIC *Annual Statement Instructions*.

Column (7) (Applicable Notes) This column contains references to the Notes to the Instructions that apply to each item listed on the checklist. The company should carefully read these notes before submitting a filing.



MONTANA INSURANCE DEPARTMENT
840 HELENA AVENUE
HELENA, MONTANA 59601
(406) 444-2040

2008
ANNUAL PREMIUM
TAX STATEMENT
LIFE COMPANIES

Insurer Name				NAIC Number	
Company Mailing Address		check if new <input type="checkbox"/>	City	State	Zip Code
Tax Contact Mailing Address		check if new <input type="checkbox"/>	City	State	Zip Code
State of Domicile		Tax & Fee Contact Person		Tax Contact Person Telephone Number	
Administrative Office Telephone and Fax Numbers			Toll Free Telephone Number for Policyholder Inquiries		

SCHEDULE A -- TAXABLE PREMIUM CALCULATION

PREMIUMS

- | | | | |
|----|--|----------|-----|
| 1. | Gross life premiums (Ann. Stmt: L/H-pg 24, ln 1, col 5; Health-pg 29, ln 13, col 1) | \$ _____ | [1] |
| 2. | Direct A & H premiums (Ann. Stmt: L/H-pg 24, ln 26, col 1; Health-pg 29, ln 12, col 1) | \$ _____ | [2] |
| 3. | Membership and policy fees and miscellaneous fees | \$ _____ | [3] |
| 4. | Total Premiums Collected (add lines 1 thru 3) | \$ _____ | [4] |

DEDUCTIONS

Dividends paid during the current year but credited to the policyholder in a prior year may not be deducted. Dividends which should have been deducted in a prior year may not be deducted in the current year. Policy coupons are to be considered as dividends for the purpose of this report.

- | | | | |
|---|---|----------|-----|
| 5. | Dividends paid or credited to policyholders on Life policies
(Ann. Stmt. L/H-page 24, line 6.5, column 5)* | \$ _____ | [5] |
| 6. | Dividends paid or credited to policyholders on A & H policies
(Ann. Stmt. L/H-page 24, line 26, column 3)* | \$ _____ | [6] |
| * If the dividend deduction does not match the dividends reported on the Montana state page, attach a separate schedule reconciling the difference. | | | |
| 7. | Medicare Title XVIII exempt from state taxes or fees | \$ _____ | [7] |
| 8. | Total Deductions/Exemptions (add lines 5, 6 and 7) | \$ _____ | [8] |
| 9. | NET TAXABLE PREMIUMS per 33-2-705(1), MCA (line 4 less line 8) | \$ _____ | [9] |

SCHEDULE B -- COMPUTATION OF TAX AND FEES

10.	Premium Tax per 33-2-705(2), MCA (2.75% of line 9)	\$ _____ [10]
11.	Retaliatory Amount per 33-2-709, MCA (from Schedule D, Line 3 <u>or</u> 4)	\$ _____ [11]
12.	TOTAL TAXES (add lines 10 and 11)	\$ _____ [12]
13.	Montana premium tax quarterly pre-payments	\$ _____ [13]
14.	Overpayments of prior year premium taxes (as confirmed by credit letter)	\$ _____ [14]
15.	20% of "Class B" Certificates of Contribution from the Montana Life & Health Insurance Guaranty Assoc. issued in the years 2003-2007, per 33-10-230, MCA (ATTACH CERTIFICATES OF CONTRIBUTION)	\$ _____ [15]
16.	100% of Assessments paid in 2008 to the Montana Comprehensive Health Association, excluding HIPAA Plan Liability Assessments per 33-22-1513(6), MCA (PROOF OF PAYMENT AND ASSESSMENT LETTER MUST BE ATTACHED)	\$ _____ [16]
17.	Empowerment Zone New Employees Tax Credit per 33-2-724, MCA (include copy of certification from Montana Department of Labor and Industry)	\$ _____ [17]
18.	Gross Deductions (add lines 15, 16 and 17)	\$ _____ [18]
19.	Allowable Deductions (enter the smaller of line 10 or line 18)	\$ _____ [19]
20.	Total payments and credits (add lines 13, 14 and 19)	\$ _____ [20]
21.	If line 12 is larger than line 20, DIFFERENCE is TAX DUE	\$ _____ [21]
22.	COMPANIES <u>MUST REMIT \$1,900</u> IN PAYMENT OF ALL MONTANA FEES	\$ <u>1,900.00</u> [22]
23.	TOTAL REMITTANCE (add lines 21 and 22)	\$ _____ [23]
24.	If line 20 is larger than line 12, DIFFERENCE is ANNUAL TAX OVERPAYMENT	\$ _____ [24]

OVERPAYMENT must be carried forward and used to offset future periodic payments.

The above statement, and attached Schedules C and D, are true and correct reports of premiums collected and of authorized deductions pertaining to business transacted in Montana in the past calendar year and are in accordance with the requirements of the applicable statutes.

Title of Officer	Name of Officer (Type or print)
Date	Signature of Officer

- TAX RETURN CHECKLIST Did You Remember to:
- 1. _____ Attach Annual Statement Montana State Page?
 - 2. _____ Include Total Remittance from line 23 (at least \$1,900)?
 - 3. _____ Attach documentation for tax credits on lines 15, 16 and 17?
 - 4. _____ Indicate your company's NAIC number on front of the tax form?
 - 5. _____ Attach explanations for any unusual or extraordinary items?
 - 6. _____ Fully complete Schedules C and D and attach them to this statement?

CO. NAME _____ NAIC # _____ STATE OF DOMICILE _____


**SCHEDULE C -- RETALIATORY SCHEDULE
ATTACHMENT TO 2008 ANNUAL PREMIUM TAX STATEMENT - LIFE COMPANIES
STATE OF MONTANA**

	(A) MONTANA	(B) STATE OF DOMICILE
1. Montana Net Premiums (from Schedule A, Line 9)	_____	_____
2. Tax Rate	<u>2.75%</u>	_____
3. Premium Tax	_____	_____
4. Annuity Considerations	N/A	_____
5. Annuity Tax Rate	N/A	_____
6. Annuity Premium Tax	N/A	_____
7. Certificate of Authority Continuation Fee per 33-2-708(1)(a), MCA	<u>\$ 1,900.00</u>	_____
8. Annual Statement Filing Fee	N/A	_____
9. Assessment for Insurance Department Operations	N/A	_____
10. Other (explain)_____	N/A	_____
11. Other (explain)_____	N/A	_____
12. Total Montana Taxes & Fees (sum of lines 3 and 7, col. A)	_____	XXXXXXXXXXXX
13. Total State of Domicile Taxes & Fees (sum of lines 3, and 6 thru 11, col. B)	XXXXXXXXXXXX	_____


**SCHEDULE D -- CALCULATION OF RETALIATORY TAX
ATTACHMENT TO 2008 ANNUAL PREMIUM TAX STATEMENT - LIFE COMPANIES
STATE OF MONTANA**

1. Enter Amount from Schedule C, Line 13, Col. B _____
2. Enter Amount from Schedule C, Line 12, Col. A _____
3. If Schedule D, Line 1 is larger than Schedule D, Line 2 enter difference on
this line and transfer this amount to Schedule B, Line 11 _____
4. If Schedule D, Line 2 is larger than Schedule D, Line 1 enter \$0 on this
line and transfer \$0 to Schedule B, Line 11 _____

6.6.2708 Application of Refund (1) If an insurer, on a form approved by the commissioner and under oath, notifies the commissioner that it is entitled to a refund, the commissioner may authorize a refund. An insurer is not entitled to receive interest on the refund.

 <p>MONTANA INSURANCE DEPARTMENT 840 HELENA AVENUE HELENA, MONTANA 59601 (406) 444-2040</p>		<p>PREMIUM TAX REFUND REQUEST FORM</p> <p style="text-align: right;">6.6.2708, ARM</p>	
Insurer Name			NAIC Number
Mailing Address	City	State	Zip Code
State of Domicile	Contact Person and Telephone Number		FEIN Number
Reason for decrease in estimated premium tax liability for 2009. 		Method of calculation for refund. Calculation subject to audit by Department A. 2008 Overpayment \$ _____ 2009 Pre-payment Requirement: B. 100% of 2008 Tax \$ _____ or C. 90% of 2009 Tax * \$ _____ 1. 2008 Overpayment \$ _____ (A from above) 2. Prepayment required \$ _____ (B or C from above) 3. Amount of Refund \$ _____ (1 minus 2) * Please explain in left hand column.	
Title of Officer		Name of Officer (Type or Print)	
Date		Signature of Officer	
Subscribed and sworn to before me this _____ day of _____, 20 _____. <div style="text-align: right; margin-right: 100px;"> _____ (Notary Public) </div> Residing at _____ My commission expires _____			

6.6.2707 Cessation of Business (1) If an insurer, on a form approved by the commissioner and under oath, notifies the commissioner that it is no longer writing new or renewing existing insurance policies of any type in the state, the commissioner may waive the periodic payment requirements established in these rules.

		MONTANA INSURANCE DEPARTMENT 840 HELENA AVENUE HELENA, MONTANA 59601 (406) 444-2040		CESSATION OF BUSINESS NOTIFICATION FORM 6.6.2707, ARM	
Insurer Name				NAIC Number	
Mailing Address		City		State	Zip Code
State of Domicile	Contact Person and Telephone Number			FEIN #	
Explanation of adjustment to quarterly tax pre-payment.					
Title of Officer			Name of Officer (Type or Print)		
Date			Signature of Officer		
Subscribed and sworn to before me this _____ day of _____, 20__.					
_____ (Notary Public)					
Residing at _____					
My commission expires _____					



Montana Insurance Department
840 Helena Avenue
Helena, MT 59601
406-444-2040

2008 FUNERAL INSURANCE ACTIVITY REPORT

FORM MUST BE COMPLETED AND RETURNED EVEN IF NOTHING TO REPORT
(REPORT DUE MARCH 1)

(Name of Insurance Company)

(N.A.I.C. #)

(Mailing Address - Street or P.O. Box)

(City - State - Zip)

ARM 6.6.1008 provides that the Commissioner may require issuers of funeral insurance to file a supplement to the annual statement. Funeral insurance is a type of life insurance as defined in MCA 33-20-1501 and may be included in a life insurance policy or a limited policy or certificate with a guaranteed death benefit.

1. MONTANA FUNERAL INSURANCE DATA

Total number of individual policies written in 2008	_____
Total number of group policies written in 2008	_____
Total number of certificates issued in 2008	_____
Total number of lives insured in 2008	_____
Total value (death benefit) issued in 2008	\$ _____
Total premium written in 2008	\$ _____
Total number of policies/certificate cancellations, lapses and terminations in 2008	_____
Total number of policies/certificates paid in 2008	_____
Total amount of death benefits paid in 2008	\$ _____

2. MONTANA AGGREGATE FUNERAL INSURANCE DATA

Total number of individual policies in force at 12/31/2008	_____
Total number of group policies in force at 12/31/2008	_____
Total number of certificates in force at 12/31/2008	_____
Total number of lives insured at 12/31/2008	_____
Total value (death benefit) of coverage in force at 12/31/2008	\$ _____
Total number of policies/cancellations, lapses, and terminations from 1/1/2008 through 12/31/2008	_____
Total number of policies/certificates paid from 1/1/2008 through 12/31/2008	_____
Total amount of death benefits paid from 1/1/2008 through 12/31/2008	\$ _____

(Type name of person preparing report)

(Telephone # and extension)

(Email address)



State of Montana

**LIFE AND DISABILITY INSURERS
QUARTERLY PREMIUM TAX PAYMENT
DUE DATE: APRIL 15, 2009**

Insurer Name: _____

NAIC # _____ Check Number: _____

QUARTERLY TAX PAYMENT CALCULATION

1. '08 premium tax liability (#10 from tax return) or 90% of anticipated 2009 tax \$ _____
2. Less allowable deductions (*See instructions on back*) \$ _____
3. Total 2009 quarterly pre-payment (*line #1 - #2*) \$ _____
4. Enter 25% of the amount on line #3 \$ _____
5. Amount of 2008 overpayment applied to this payment (*see line #24 of the tax return*) \$(_____)
6. **QUARTERLY AMOUNT REMITTED (#4 - #5)** \$ _____
(*Instructions on back*)

Mail payment to: Montana Ins Dept - 840 Helena Ave - Helena MT 59601

SAI-22 (10/08)



State of Montana

**LIFE AND DISABILITY INSURERS
QUARTERLY PREMIUM TAX PAYMENT
DUE DATE: SEPTEMBER 15, 2009**

Insurer Name: _____

NAIC # _____ Check Number: _____

QUARTERLY TAX PAYMENT CALCULATION

1. '08 premium tax liability (#10 from tax return) or 90% of anticipated 2009 tax \$ _____
2. Less allowable deductions (*See instructions on back*) \$ _____
3. Total 2009 quarterly pre-payment (*line #1 - #2*) \$ _____
4. Enter 25% of the amount on line #3 \$ _____
5. Amount of 2008 overpayment applied to this payment (*see line #24 of the tax return*) \$(_____)
6. **QUARTERLY AMOUNT REMITTED (#4 - #5)** \$ _____
(*Instructions on back*)

Mail payment to: Montana Ins Dept - 840 Helena Ave - Helena MT 59601

SAI-22 (10/08)



State of Montana

**LIFE AND DISABILITY INSURERS
QUARTERLY PREMIUM TAX PAYMENT
DUE DATE: JUNE 15, 2009**

Insurer Name: _____

NAIC # _____ Check Number: _____

QUARTERLY TAX PAYMENT CALCULATION

1. '08 premium tax liability (#10 from tax return) or 90% of anticipated 2009 tax \$ _____
2. Less allowable deductions (*See instructions on back*) \$ _____
3. Total 2009 quarterly pre-payment (*line #1 - #2*) \$ _____
4. Enter 25% of the amount on line #3 \$ _____
5. Amount of 2008 overpayment applied to this payment (*see line #24 of the tax return*) \$(_____)
6. **QUARTERLY AMOUNT REMITTED (#4 - #5)** \$ _____
(*Instructions on back*)

Mail payment to: Montana Ins Dept - 840 Helena Ave - Helena MT 59601

SAI-22 (10/08)



State of Montana

**LIFE AND DISABILITY INSURERS
QUARTERLY PREMIUM TAX PAYMENT
DUE DATE: DECEMBER 15, 2009**

Insurer Name: _____

NAIC # _____ Check Number: _____

QUARTERLY TAX PAYMENT CALCULATION

1. '08 premium tax liability (#10 from tax return) or 90% of anticipated 2009 tax \$ _____
2. Less allowable deductions (*See instructions on back*) \$ _____
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(*Instructions on back*)

Mail payment to: Montana Ins Dept - 840 Helena Ave - Helena MT 59601

SAI-22 (10/08)

QUARTERLY TAX PAYMENT INSTRUCTIONS

Line #2 Instructions

The quarterly amounts should be reduced by subtracting the following **allowable deductions**:

A. Anticipated 2009 tax offsets (20% of Montana Life and Health Insurance Guaranty Association assessments paid during tax years 2004-2008):

\$ _____

B. Montana Comprehensive Health Association assessments:
(excluding HIPAA Plan Liability assessments)

\$ _____

Total allowable deductions to transfer to line #2 (on front):

\$ _____

Other Instructions

Please do not combine amounts for affiliated companies on a single check.

If the amount on line #3 is zero or a negative amount: Enter zero on line #3 and #6 on all 4 payment vouchers and return all 4 vouchers to this office by April 15, 2009.

If insurer deems the total 2009 quarterly pre-payment requirement on line #3 to be a minimal amount (less than \$100), combine all 4 payments in one check, complete all 4 vouchers and submit the payment on or before April 15, 2009.

If premium writings have declined from the previous year, you may substitute the amount on line #1 with an amount equaling 90% of the 2009 anticipated premium tax.

If you have any questions, please contact our office at (406) 444-2040.

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